MINUTES

HEALTH CARE TASK FORCE

October 23, 2008
9:00 a.m. - 3:30 p.m.

(Subject to approval of the Health Care Task Force)

Cochairman Representative Gary Collins called the meeting to order at 9:08 a.m. Members present were: Cochairman Senator Dean Cameron and Senators Joe Stegner, Patti Anne Lodge, Tim Corder, John McGee and Elliot Werk; and Representatives Sharon Block, Jim Marriott, Carlos Bilbao, Fred Wood and Margaret Henbest. Senator John Goedde and Representative John Rusche were absent and excused. Legislative Services staff present were Paige Alan Parker, Amy Castro and Charmi Arregui.

Others present were Kathie Garrett, Idaho Association of Developmental Disabilities Agencies; Lisa Hines, Heather Taylor, Dora DeCamp and Jason Bird, Boise State University; Patti Campbell and Paul Leary, Idaho Department of Health and Welfare; Molly Steckel, Idaho Medical Association; Kurt Stenbridge, Glaxo Smith Kline; Mark Peterson, St. Luke's Regional Medical Center; Cheryl Dunham, Idaho Association of Health Plans; Tom Shaw, Idaho Association of Health Underwriters; Julie Taylor, Blue Cross; Kathy Moore and Scott Davis, West Valley Medical Center; Ken P. Burn, AARP; Lyn Darrington, Regence Blue Shield of Idaho; Corey Gurber, Business Psychology Associates; Benjamin Davenport, Saint Alphonsus Regional Medical Center; Toni Lawson and Steve Millard, Idaho Hospital Association; Michele Sherrer, Gem County Commissioner; Tony Poinelli, Idaho Association of Counties; Roger Christensen, Bonneville/CAT Bd.; Cathy Holland-Smith and Keith Bybee, Legislative Services Office; Roger Christensen, Bonneville County Commissioner; Woody Richards, Attorney/Lobbyist; Michele Sandberg, SYNC, LLC; Mike Berry, American Health Values; Rakesh Mohan, Office of Performance Evaluation and Representative Phylis King.

Representative Marriott moved to approve the minutes for the September 16, 2008, meeting of the Task Force. Senator McGee seconded the motion. Representative Bilbao corrected the spelling of his name. The motion with the correction carried by unanimous voice vote.

NOTE: All copies of presentations, reference materials, and handouts will be on file at the Legislative Services Office (LSO).

Senator Stegner, Cochairman of the Task Force's Mental Health Subcommittee, reported on the status of the Mental Health Transformation Project. This Task Force has not yet adopted the recommendations contained in the Western Interstate Commission on Higher Education (WICHE) report. WICHE still needs to prepare an implementation plan and a Transformation Group will need to be appointed to implement the plan. **Senator Stegner** is working with Governor Otter's administration which has shown interest and has asked for additional information. **Senator Stegner** was optimistic that there would be some action on the Project before the legislative session starts.

Representative Block, Co-chairwoman of the Subcommittee, stated that the Project will require collaboration between the Governor's Office, the Legislature, the counties and the appropriate departments that are involved. Now is the time for due diligence.

Cochairman Collins extended his appreciation to the cochairs of the Subcommittee and the effort and hours spent working on this issue, allowing the Project to move forward.

Cathy Holland-Smith, Division Manager of the Budget and Policy Analysis Unit, LSO, provided a budget overview of the Catastrophic Health Care (CAT) Program and indigent care. These programs provide a safety net for the uninsured and underinsured. She noted that Idaho does not have any public hospitals. The key providers in Idaho are county hospitals, community health centers, and the CAT system. Handout #1 provides the CAT funding history provided to the state as required by *Idaho Code §31-3503A(3)*. The CAT program is an incident based system directed to individual catastrophic cases as opposed to ongoing illnesses. The process requires an individual to apply to the board of county commissioners, which reviews the application to determine the individual's ability to contribute toward his own health care. The individual may be required to make some kind of contribution to the cost. There is a $10,000 per individual, per year, deductible paid by the county. The state bears the burden for any expenses exceeding the $10,000. Those expenses are paid from the general fund.

Ms. Holland-Smith addressed some major challenges in regard to the budget situation. CAT has submitted a supplemental request for $2.5 million for 2009 and another $2.5 million for 2010. The data shows the total amount spent increased from $25.3 million in 2002 to $38.4 million in 2007 while the number of persons served decreased from 5,498 in 2002 to 3,706 in 2007. The two largest categories for the number of people served are general and mental health. The auto accident category was the largest average dollar amount per case. Men and women were equally served by the CAT program.

Senator Werk wanted clarification about how multiple incidents are counted. **Ms. Holland-Smith** stated that the dollar amount for mental health per person would be the total cost over a twelve month period no matter how many times the system was accessed.

Ms. Holland-Smith explained that the CAT program residency requirement does not speak to the legality of a resident but the requirement that the individual be a resident of the county. The CAT program does not track illegal immigrants.

Ms. Holland-Smith stated that the funding responsibility of the state has gone up significantly, due primarily to the rising costs of health care, that typically exceed the $10,000 deductible the county pays. Policy issues also affect increases because there is no mechanism to trigger a change in that $10,000 county deductible which has stayed at $10,000 since the program began. In 2005, counties were allowed to share the tobacco settlement money in smoking related health care issues on a case-by-case, year-by-year basis. The Legislature approves such allocations from the Millennium Fund.

Cochairman Cameron asked how Idaho compares to other states for this type of program. **Ms. Holland-Smith** responded that other states with a safety net system are extremely varied, ranging from supporting hospitals to providing insurance.

Cochairman Cameron requested that **Ms. Holland-Smith** elaborate on what would happen if

the supplemental request for 2009 and 2010, totaling $5 million, could not be funded. **Ms**. **Holland-Smith** said that the counties could either try to negotiate with the providers for lower rates and reimbursements or sue the state. The courts do not view this as an optional program but a mandate**. Ms. Holland-Smith** noted that as the state has reined in Medicaid spending, the CAT program has been impacted because costs have been pushed into the CAT program. Medicaid has previously supported this system by making the payments more robust than they are now. **Cochairman Cameron** thought that the state would be sued by the hospitals rather than the counties, since the counties would be held harmless.

Cochairman Cameron commented that apparently some states run their safety net system through their Medicaid program and thereby receive federal matching dollars. The dilemma has been how to let counties maintain control and yet use a statewide system. "Is there any information about those states that run the program through their Medicaid system?" **Ms. Holland-Smith** replied that the efforts to investigate that approach were tabled. However, she would be glad to get some information for the Task Force. One of the challenges on that issue is that many of the CAT program applicants are not eligible for Medicaid, unless they have custody of a Medicaid eligible child or are permanently disabled.

Senator Lodge asked if the liability portion of the state required auto insurance, including insurance for ATVs, could pay for the motor vehicle accident costs, one of the largest costs showing on the report. **Cochairman Cameron** said that some policies have a limit of $25,000 so a large claim would have a balance outstanding. Also, some individuals drive without the required insurance and the hospitals are required to provide treatment, so the hospitals turn to the counties for reimbursement. **Senator Lodge** suggested that maybe this issue should be addressed so that these people are carrying sufficient insurance to cover these costs. **Cochairman Collins** noted that the state has a very small liability limit.

Senator Corder followed up on **Senator Lodge's** question by asking how much an insurance company should be paying? He asked whether the counties know if an insurance company owes money and whether the state pursues this issue or just pays the costs over the $10,000 county deductible? **Ms. Holland-Smith** suggested that the counties would be better able to answer those questions.

Senator McGee stated that two years ago a law was passed requiring proof of legal residency before state benefits could be received and asked why this isn't required for this program? **Ms. Holland-Smith** answered that the counties made such a proposal that was not accepted by the Legislature. She also commented that unreimbursed providers may have issues if the counties and the state refused to pay when an illegal has been provided medical services.

Representative Marriott asked what triggers eligibility for this program and whether reimbursement is made at the Medicaid rate versus the regular rate. **Ms. Holland-Smith** said that the trigger is the need for medical care at the point of service where the patient is asked to fill out insurance forms, Medicaid forms, or an application for county reimbursement. Asking for payment is part of the day-to-day provider business activity. As far as the amount of reimbursement is concerned, Medicaid reimbursement is less that of Medicare and it is significantly less than what private insurance pays. She suggested that someone from Health and Welfare may be able to speak more to that point.

Representative Marriott asked if someone was not eligible for Medicaid, had a job but could not pay, would he still be eligible. **Ms. Hollan-Smith** indicated that he would be eligible.

Tony Poinelli, Idaho Association of Counties (IAC), introduced **Michele Sherrer**, Gem County Commissioner and Chair of the IAC Health and Human Services. **Mr. Poinelli** distributed a flow chart of the County Medical Indigency process and a history of the CAT program from its origination to 2006.

Ms. Sherrer provided a view of the CAT program from the county perspective. The CAT program concerns the medical needs of residents throughout the counties who are our neighbors. It requires a difficult balance between what the Idaho Code requires the counties to pay through property tax dollars. All of the indigent funds are property tax dollars. The job of determining who receives these dollars is one of the most difficult decisions a commissioner makes. The CAT board is a pooling of all the counties in partnership with the state. Those who receive services are requested to reimburse the counties or the CAT board. This is done on a 10% county/90% state basis. One of the challenges for the CAT program is the lack of cost constraints. Although the CAT program applies only to emergency medical care, not ongoing care, there is no upper limit.

Ms. Sherrer explained that every county handles this process a little bit differently. Every year IAC holds a conference where the standardized CAT program application is reviewed and explained. There are always turnovers of commissioners and staff. Also, there is training on how to interview people compassionately and still ask the right questions and get information, stressing confidentiality. Some hospitals are cooperative and get as much information as possible, while others may only get a name and signature.

Representative Bilbao asked if the indigency fund paid for federal and state prisoners incarcerated in the county jail. **Ms. Sherrer** said it does not. Those costs are billed out to the state.

Mr. Poinelli added information regarding liens. After an individual has been declared indigent, and the lien is filed, there have been times when an individual has requested the commissioners to release the lien so that they can do a refinance. There have been cases where the lien has been released, the refinancing occurs and the lien is refiled.

Representative Marriott asked when is the lien filed. **Ms. Sherrer** said that a lien is filed as soon as an application is received by the county. If the person is found not to be indigent, the lien is lifted. **Representative Marriott** questioned whether every hospital starts the CAT program process on every accident. **Ms. Sherrer** answered no. Some hospitals are very good about getting all the information and only submit applications for those that are either clearly or questionably indigent. Other hospitals submit applications for everyone. **Mr. Poinelli** added that Idaho-based hospitals do work with the counties and get as much information as possible on the submitted application. There are problems with some of the out-of-state hospitals, especially up North.

Mr. Poinelli stated that some potential improvements could be a notification process to alert the counties in the event that the individual is potentially Consolidated Omnibus Budget Reconciliation Act (COBRA) eligible. There are some insurance benefits if that eligibility is identified early enough. This notification could be from the employer early on, not 180 days

later. **Cochairman Cameron** asked from whom and to whom the notification should be made. **Mr. Poinelli** replied that if the county receives the CAT program application from the hospital within 30 days, the county could investigate whether COBRA eligibility existed. However, when the applications are submitted 180 days after the fact, it is too late to apply for COBRA. **Cochairman Cameron** wanted to know if there was a deadline when the application had to be submitted. **Mr. Poinelli** explained that there were two processes. The emergency application has to be submitted within 31 days. The 180 day delay comes into play when the provider applies to other potential payers which are denied.

Representative Marriott asked for clarification about COBRA, extended insurance coverage available to a former employee who had been covered by employer provided health insurance. **Mr. Poinelli** said that if the former employee failed to pay the COBRA premium and the county determines that the CAT program applicant is COBRA eligible, the county may pay the premiums for a certain period of time. **Cochairman Cameron** said the former employee had 60 days to choose COBRA after termination even if the individual initially declined the continuing coverage. **Representative Henbest** asked if coverage was retroactive. **Cochairman Cameron** stated it was.

Representative Henbest inquired about providers other than hospitals. **Mr. Poinelli** responded that in many cases the hospital takes that responsibility and submits the application for all provider costs. The requirement is that any provider listed on the application be notified.

Mr. Poinelli listed the CAT program issues that counties believe are important:

- The development of a utilization review process for the benefit of the county and state programs.
- Better communication and more training to update hospitals, counties, state representatives, officials and legislators.
- Addressing the policy issue of residency.
- Accident claims that could be avoided through a mandatory motorcycle helmet law.
- An insurance pool that businesses could buy into.
- Addressing a new federal law that prohibits using information provided on the application to gather employment information.
- Allowing hospitals to transfer patients to nursing homes to save costs.
- Should the reciprocal agreement with the state of Washington be rescinded due to the problems the ten northern counties are having with out-of-state facilities? Washington will not pay Idaho providers because its has a Medicaid-based program. IAC is currently working on this issue.
- In 1989-1990, federal legislation was passed repealing the medically indigent law and creating a medically needy program. However, the medically indigent law was reinstated the following year because the new program would have required counties to expand coverage to everyone and would have cost between $40 - 70 million.
- At the request of the Legislature a few years ago, the counties and the Department of Health and Welfare worked together to develop a pilot program in six counties that would have accessed Medicaid funds. The plan was dropped when the Governor's focus shifted to Medicaid reform. This pilot program could be reconsidered if the counties felt that the effort would be worthwhile.

Senator Corder asked if there is data on the uninsured motor vehicles or worker's

compensation dollars that are lost and if the counties contact the insurance companies to see if these claims may be paid. **Mr. Poinelli** responded that the answer is both yes and no. Some of the information is tracked and some could be tracked. If the county determines that the individual has sufficient insurance coverage, the county will deny the application. That information is not tracked. If an application is approved, no additional action is taken. **Senator Corder** asked if the dollars **Ms. Holland-Smith** reported earlier for vehicle accidents involved people who are uninsured or underinsured motorists. **Mr. Poinelli** stated that is probably true in some cases, depending on whether it is above the required minimum coverage. The county can go after the minimum coverage but that may not pay the whole bill. **Senator Corder** said that would be information needed to determine what the limits should be. **Mr. Poinelli** volunteered to see if there were other options.

Senator Werk asked about the services provided by hospitals vs. nursing homes. **Mr. Poinelli** stated that the counties have been informed that the CAT board does not pay nursing home costs. Rehabilitation services could be obtained from a nursing care facility at considerably less cost than at a hospital. It would be beneficial to have guidelines for those types of situations so settings other than a hospital could be used. **Senator Werk** imagined a scenario where a serious auto accident resulted in a serious brain injury and acute hospital care. Once the emergency is over and rehab services begin, does the CAT program end services? **Mr. Poinelli** said the immediate emergency care would be provided and if the treating physician included rehabilitation in the treatment plan, the individual would be eligible for an additional six months of CAT fund paid services. **Senator Werk** asserted that having the counties in a position to direct a treatment plan would not be a good thing and there needs to be some kind of control system to provide the levels of care needed at different stages in an appropriate setting which could lower the overall cost. **Mr. Poinelli** concurred.

Kathy Moore, CEO, West Valley Hospital, provided information on the CAT program from a hospital point of view. **Ms. Moore** stated that her background as a Caldwell, Idaho, native allowed her to relate to the people using this system as her neighbors. The West Valley Hospital does not turn anyone away from their emergency department whether it is an emergency or not. Approximately 60% of the emergency department visits are minor or minor urgent cases, due to providers who are unwilling to care for the indigent and uninsured. West Vally Hospital continues to provide these nonprofitable services, while limited service providers are redirecting the profitable outpatient cases and high dollar procedures to physician owned facilities. As a facility, West Valley provides $11.4 million to charity and uncompensated care annually which equates to about 20% of the net revenue of the hospital. Because of the health care crisis across the country, West Valley Hospital is grateful that Idaho has created the CAT program to share the burden. West Valley Hospital tries to qualify indigent patients under other programs if possible because reimbursement is better than what is received from the CAT fund.

Ms. Moore elaborated on some of the other strengths that comes from the CAT fund in its roll as a safety net. The application allows for services of all the providers in the health care event to be included on one application. Patients also have the ability to pay back at that Medicaid rate. The bills are consolidated so there is just one payment for the patient, thus reducing complexity. Some counties, such as Owyhee and Payette, are efficient and compassionate in the process. However, the interviewers in some counties use tactics to discourage patients from applying and create significant barriers by requiring substantial and duplicative documentation. Many time applicants are not treated with respect at a very stressful time. West Valley has two people that just help with these applications. From the hospital's perspective,

the cases are dragged out and the process delayed by some counties in the hopes that the application process will be dropped. The application is very comprehensive, which is good from a hospital administrator and a taxpayer perspective. Counties have the discretion to determine whether a case is an emergency or nonemergency, which may be in contradiction to the provider's opinion.

Ms. Moore stated that each county is different and these differences are significant: increasing complexity, decreasing efficiency and adding to program administration cost. The hospitals are seeing liens being placed on the homes of people who are not financially responsible for another's health care costs. As an example, a lien was placed on the home of a girlfriend of a CAT progam applicant. When the county was asked about this, the answer was that if she didn't like it, he could withdraw the application.

Ms. Moore offered that there are barriers to accessing services and payment for people that really are in need. Some of the improvements to the CAT program might include:

- The county representative needs to show more respect and compassion for the applicant, assisting and improving communication in a courteous and professional manner.
- Simplify the program by making it similar to the Medicaid assistance program requirements. The reformed Medicaid process has resulted in less complication and improved efficiencies for all parties.
- There is a need to confirm that individuals are in true need. However, once that is confirmed the process should proceed and not be overanalyzed and burdened with repeated data requests.
- The 10-day rule appears to be arbitrary.
- The process should be standardized in all counties and the counties and providers should be trained in the standardized process so they, in turn, can educate the patients.

Ms. Moore stated that there are other issues that the hospitals should consider.

- Under the Civil Rights Act, hospitals are required to provide interpretive services to any minority that represents 10% of the population. Hospitals believe the counties need to invest in those services as well.
- Idaho legislation passed in 2007 disqualified all illegal residents from the CAT program for nonemergency treatment. Although this legislation was passed with every good intention of saving money, the consequence has been to shift this cost from the state and county to the hospital and physician which ultimately increases health care. The taxpayers ultimately pay these costs through higher insurance premiums.
- There is an opportunity to work on preventative and/or early intervention. For instance, a cancer that has not metastasized is not considered life-threatening and does not qualify under the CAT program. If the tumor is not treated, it will grow and eventually the cancer treatment will become an exorbitant cost to the state.
- Consolidating the CAT program under the Department of Health & Welfare would streamline all assistance programs under one umbrella and maximize resources.

- A less incident based system would decrease the cost to the state as a whole. Partial or tiered levels of assistance versus a full denial would add value.
- The Idaho statute needs to be changed to reduce the bureaucracy of the program. The complexity of the current program is overwhelming to a patient going through tragic times.

Senator Corder referred back to the auto accidents and asked if motor vehicle insurance coverage is tracked. **Ms. Moore** answered that the hospital could run reports but does not actively track that information. What is seen at West Valley Hospital is the motor vehicle accident where the individual who is liable is uninsured and cannot pay his bill or the bill of the other(s) involved.

Senator Corder asked about the situation where a person who is injured on someone else's property can pursue a damage claim against the property owner. **Ms. Moore** said that the hospital does not pursue those cases against a third party. Regarding COBRA, the hospital has paid the premium in order to get reimbursed under the prior employer's insurance.

Representative Henbest questioned the quality of the decision-making at the county level as CAT program eligibility. **Ms. Moore** stated that the review should be at the state level. **Representative Henbest** asked what is done when a lien is placed on the property of a person who is not liable for payment. **Ms. Moore** responded that hospital personnel approach the county on the matter but sometimes they get stonewalled. These are the types of tactics alluded to regarding the barriers put up to keep people who are truly in need from obtaining help. **Representative Henbest** suggested that this may be an issue for the Attorney General.

Representative Henbest referred back to the Medicaid reimbursement level vs. private insurer reimbursement, noting that Medicaid is 81.5% of costs with a Diffuse idiopathic skeletal hyperostosis (DISH) payment offset and that Blue Cross and Primary Health negotiate payments that are not paid at cost. She asked what is the CAT program payment from those reimbursement schemes. **Ms. Moore** stated that West Valley Hospital actually loses money when caring for a Medicaid patient and doesn't make money on Medicare patients because Medicare excludes costs that are not considered direct patient care related. The difference must be made up through private insurance payments which are discounted, but still above the Medicaid and Medicare rates. **Representative Collins** requested **Paige Parker** to put that information together.

Representative Marriott asked what would be accomplished by having the utilization review done at the state level. **Ms. Moore** said that it would probably save dollars in managing catastrophic case care. It would also be an advantage to work with a committee of providers and identify what is emergent and nonemergent to help streamline the process and standardize the process at the county level so that time deadlines would not be missed. Managing cardiac and diabetes cases and engaging in preventative care would move the CAT away from an incident based program to one that manages health care.

Roger Christensen, Bonneville County Commissioner and a CAT Board member, discussed the CAT program from the Board's point of view. A strength of the program is the protection it provides to property taxpayers. This year, approximately $26 million has been paid to providers by the CAT fund. The actual dollars are a little higher but some are carried over to the next budget year. One of the weaknesses of the CAT program is that the requirements are set by

statute. The program is triggered when the application is made. Claims are not subject to appropriation limits. The CAT board has no ability to control cost since the utilization review is made after the fact. There is a lack of direct medical review as the cases are happening. **Commissioner Christensen** opined that CAT has been administered in a cost-effective manner, with administrative costs running at 1-2 percent of claims.

Commissioner Christensen offered observations for improvements and changes based on the frequency of the cases the Board sees:

- Undocumented persons – the law was changed to allow for stabilization and transfer back to country of origin. **Mr. Poinelli** interjected suggesting that the bill allowed that to happen but the problem is getting the proper entity to actually transfer the individual back. **Senator McGee** corrected the statement stating that the bill did not get a print hearing.
- This is an incident based program for emergency care and doesn't address l long-term care issues very well.
- The mental health area is a very difficult issue that needs special expertise that could be handled through Health & Welfare.
- Consider legislation regarding contributing elements like mandatory helmet laws and making the failure to use a seat belt a primary offense.
- Employers could be required to provide health insurance to employees or pay into the CAT fund.
- Increase the deductible to the counties which would shift the cost to property tax. **(Commissioner Christensen** takes no position on this issue.)
- Increase the beer and wine tax and dedicate the increased revenue to the CAT fund.
- Increase the no fault liability insurance limits.
- Require proof of insurance to register a car.
- Tighter qualifications for Medicaid pushes people into the indigent status.

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In summary, **Commissioner Christensen** stated that the Legislature should understand this is an incident based program and it is difficult to set up this type of program to pay for prevention. The hospitals, doctors and counties often don't understand the scope of the program. It is up to the Legislature to change the scope of the CAT program if it wants to expand into the areas of prevention and long-term care.

Senator Corder asked if the vehicle insurance companies have been rated on how easy it is to collect reimbursements. **Mr. Christensen** stated ,as a general observation, that insurance companies have a tendency at first to not pay, but that administrators are encouraged to make sure that all collection efforts have been expended. However, that given the liability limits under existing law, the coverage is inadequate.

Senator Corder reported that the Idaho Trial Lawyers Association issued a report of the ten worst casualty insurance companies in the state and whether the CAT board could do a similar ranking. **Mr. Christensen** suggested that be left to the Legislature since it is a little outside the CAT Board's jurisdiction. The mistrust between hospitals and counties and the horror stories circulating on both sides indicates that there should be better communication.

Senator Lodge asked whether the one percent of claims paying for administrative costs includes the counties or just the state. **Mr. Christensen** responded that it was just for the state. That cost is kept down because the CAT Board is not required to do a lot of the reviews. **Senator Lodge** asked how much has been recovered this year. **Mr. Christensen** answered $3.7 million.

Patti Campbell, Idaho Department of Heath & Welfare, reported on funding opportunities for the CAT program and whether federal funds could be leveraged to assist the counties in providing for catastrophic care. In 2004-2005, Medicaid worked with the counties to develop a program that was referred to as "County Option." The primary purpose was to implement a program for the uninsured population that would leverage federal funds through the Center for Medicare and Medicaid Services (CMS). Under County Option, each county would develop its own health plan and would contract with existing providers for indigent care and primary services. The population targeted was uninsured adults 19-64 who were not eligible for Medicaid and whose income felll below 185% of the federal poverty limit. A unique feature of the program was that it created a relationship between the county and the state Medicaid agency, similar to that currently existing between Health and Welfare and CMS. The funding would consist of 70% federal (drawn from Title XIX) and 30% county dollars. County Option would start with a six county demonstration and roll out over a five-year period to all 44 counties. In order to implement County Option, federal approval was needed in the form of a waiver. County Option was met with some resistence from CMS. The primary CMS concerns were: the number of eligible individuals would be capped at the county level; the proposed individual eligibility did not align with the federal rules; there was variance between the counties as to the services to be provided; County Option would supplant existing county and state CAT programs with federal funds; the cost would be $43 million over five years; and federal budget neutrality requirements meant that there had to be savings elsewhere. Due to these issues, the waiver request was never submitted.

Ms. Campbell stated that the medical needy program in the 1990's was abandoned due to cost control issues. The medical needy program was a state plan option that did not require a waiver. However, under that program, all eligible individuals who met the medical definition would have to be considered.

Representative Henbest asked whether a safety net could be provided by working with providers through a capitated program that would be incident triggered. **Mr. Poinelli** responded that one county investigated that possibility but nothing materialized.

Cochairman Collins opened the floor for a roundtable discussion.

Senator Corder commented that more answers are needed regarding vehicle insurance and the worker's compensation issues and that further discovery is needed. He noted that there is

one major worker's compensation carrier in the state (not the State Indemnity Fund) that has a practice of moving individuals into the CAT program.

Cochairman Collins stated that another Task Force meeting may be required to get answers to the questions that have been raised.

Senator Werk added that the Task Force might want to appoint a subcommittee to pursue the

issues raised regarding the CAT program.

Representative Henbest stated that this is not the first discussion about the CAT fund and its shortcomings, including, being an incident based program, without control mechanisms. There are systemic problems with the program from a health quality standpoint. The amount of dollars and number of uninsured involved would go a long way to achieve partial coverage or capitated services and prevent some of those costs. **Representative Henbest** recommended sitting down with the affected parties and discussing how to make the program more effective.

Cochairman Collins agreed.

Senator Stegner stated that while generally, the Legislature has been reluctant to create interim committees, the creation of interim committees on health care has been more successful. He suggested that the Task Force sponsor a resolution for such an interim committee. He opined that the Task Force's recommendation would be seriously considered by the Legislature. This issue is large enough for an interim committee effort.

Representative Wood stated that an indigent medical system should be part of the discussion. He stated that the definition of "indigent" should be someone who does not have immediate resources to pay for medical costs. There are X numbers of uninsured in Idaho but one-third of those people have resources to purchase health insurance but choose not to. How to get those people to purchase insurance should be investigated. **Representative Wood** endorsed **Senator Stegner's** idea of an interim committee composed of people who have spoken today plus others because putting mandates on the current system simply will not work. Trying to do this in a few months isn't going to work. It may require expertise from outside this state such as WICHE to look at a composite of how other states fund "indigent medical care," depending on how "indigent" is defined.

Senator McGee agreed with the consensus that an interim committee should study this issue. Alternatively, the mental health subcommittee of this Task Force is already in existence and could take on this issue. **Cochairman Collins** stated that the co-chairmen need to discuss this issue.

Cochairman Cameron thanked the presenters for bringing the Task Force up to speed on he CAT program. He stated that there have been good suggestions from all participants. He suggested that the hospitals and counties could identify how much time is being spent administratively per dollar collected by counties. Either a subcommittee or an interim committee would be appropriate depending on how fast the Task Force wants the matter to move. The Task Force needs to consider whether there are some things that could be done this year versus waiting a whole year.

Ms. Moore stated that today's discussions demonstrate that the issue is bigger that just CAT funding and includes how to identify and get access to affordable health care services for Idaho communities. The issue is how can the health care dollars from the state, county, hospitals and providers be invested in a statewide program that provides accessible and affordable health care coverage for all communities. **Ms. Moore** encouraged the Task Force to look at the big picture on how all of the health care dollars that are being spent and how those dollars can be brought down to the people in an affordable, preventive way that, in the long term, saves tax dollars and system cost. The dollars are there; they are just not being utilized correctly.

Senator Werk said that the abuse of the lien statute is particularly disturbing and suggested that the Task Force request the Attorney General for an opinion on the issue.

Mr. Poinelli responded that IAC has conducted training on this issue at both the Prosecutors Association meeting and the Indigent Conference. The statute is pretty straight forward: The lien is filed within 31 days after the county receives an application and it is placed on the individual receiving the services. **Mr. Poinelli** was a little surprised by the lien issue and he said that he will find out what is going on and report back to the Task Force. **Mr. Poinelli** also volunteered to check on reimbursements from worker's comp and victim's comp. There is also the issue of an individual being injured on someone else's property. The county may not have the authority or the ability to require that individual to sue the landowner. The third party application must be looked at as well.

Representative Marriott also stated that he was disturbed with the lien process. It is problematic, makes a lot of work and could be unconstitutional. That is bad procedure.

Steve Millard, Hospital Association, stated that the Association has a long history of working with the counties' association on indigent programs and protocol. Hospitals should not be filing these liens and if they are, he will find out what is happening. The Association can't tell the hospitals what to do but can recommend compliance with the law.

Senator Werk proposed that this may be a notification issue, and there may be an alternative. **Mr. Millard** said that a person presenting himself at a county office may have gone to a hospital for treatment and left against medical advice and without signing the appropriate documents. There may be no way to track those people.

Cochairman Collins announced there will be a change in the agenda and **Michele Sandberg** would present next.

Michele Sandberg, Human Resource (HR) consultant and owner SYNC, Inc, provided basic information on Variable Employee Benefit Associations (VEBAs). These organizations appear under a variety of names; REBAs, VEBAs, Variable Employee Benefits Assoc., Voluntary Employee Benefits Associations. These are organized with a trust that is available in the state of Idaho for public entities. VEBA is a creative funding source that can help public entities but ultimately face the same challenges that all of the insured and the uninsured are facing which is affordability, access and sustainability of their health care plans. The same issues appear in the public and private sector but the public sector is more magnified because there is less turnover traditionally and therefore, a more aging workforce. It becomes more difficult for public entities to continue to fund employee benefits without reducing the benefit levels or increasing the employee deductible and copay. Although technology is driving costs, the main issue is unconscious spending.

Ms. Sandberg explained that as the "baby boomer bubble" moves through the system, the ratio of workers per retiree will move from five supporting one to three supporting one and utilization from 20% to 30% or 40%. **Ms. Sandberg** explained that a VEBA HR plan helps to manage the risk. A VEBA can help by providing education and a reward system.

VEBA s have existed since 1927 and the trust has been available in Idaho since about 1990. In Idaho, the VEBA is primarily available to public employers because there is no VEBA tax

exempt trust in Idaho right now that is available to private employers. The funding options include flat dollar contributions, ongoing contributions, accumulated leave and retirement incentives. There are no contribution limits in a VEBA trust and no taxation of contributions or withdrawals. Earnings accumulate in the VEBA trust tax fee. Withdrawals can be applied to out-of-pocket expenses such as health care premiums and can be used after employment terminates. Employers have flexibility to establish vesting rules. If employees understand and manage their health care, they can accumulate the employer contributions and use those funds for retirement health care costs. These plans can help support them today but also in the future. The VEBA trust funds can help pay health care costs between the time of retirement and Medicare eligibility. Public entities are experiencing, on the average, 15% annual insurance premium increases, compared to six percent annual increases in the private sector. Five to six percent of the public employment increases can be managed and shrink the gap.
Ms. Sandberg stated that VEBA helps stabilize claims because of the financial incentives.

Senator Werk asked for a clear explanation of who may contribute to a VEBA trust. **Senator Cameron** explained that only the employer can contribute to a VEBA account.

Senator Werk asked whether there are advantages of a VEBA over a wellness incentive program. **Ms. Sandberg** explained that the VEBA trust is a nonprofit, public trust that is essentially owned by the participants. The employer sets up the account for the employees and designs the program. It is different from a flexible spending account because it is not a "use it or lose it" type of program. The employee owns the account so once the funds go in, the employee manages those accounts based on the requirements of the program. Insurance has created a use it or lose it mentality and the VEBA offers ongoing benefits. Employees tend to accumulate significant amounts in the VEBA because they are managing their health care.

Ms. Sandberg proceeded with the case study showing a plan comparison between a traditional plan and a VEBA plan. The traditional plan has no employee contribution to premium – no cost sharing. According to **Ms. Sandberg**, VEBAs allow cost sharing to occur and also creates a tax benefit for both the employee and employer.

Senator Stegner asked for an explanation of a $750 VEBA employer contribution example. **Ms. Sandberg** responded that the $750 was the initial contribution the employer would make for each employee for the year. The employer is the only one that can contribute to the VEBA under the IRS rules. The employee may use that money to help pay the health insurance premium. **Ms. Sandberg** stated that under the example, the employee's premium payment may include VEBA moneys contributed by the employer that goes to pay the premium. Although the

employee cannot contribute directly to the VEBA, the employee could utilize a health savings account to pay medical costs and save the VEBA dollars.

Representative Henbest asked if a former employee could use the VEBA dollars to pay down the house mortgage rather than use that money for health care. **Ms. Sandberg** answered that although the VEBA dollars follow the former employee, they can only be used for the authorized health care costs of the former employee and their dependents. **Representative Henbest** referred to an example of interest of six percent and an average of ten percent. Hypothetically, could the $750 be reduced to $375 as in today's market. **Ms. Sandberg** said that they could lose if they opted for a variable fund instead of the stable fund where it wouldn't lose money.

In response to **Representative Marriott**, **Ms. Sandberg** explained that it is advantageous for both the employer and the employee to use the tax exempt VEBA to pay for health care benefits, thus reducing tax liability and giving the employee a higher benefit compensation. A VEBA can be used: (1) to fund future health care costs; (2) create compensation and savings; and (3) encourage and engage the employee in the process. **Ms. Sandberg** stated that by sharing in the premium the employee and employer save taxes and the employer is able to contribute more money into the VEBA. Savings may be compounded over time which will help manage out-of-pocket expenses when retirement occurs.

Ms. Sandberg summarize by saying that employees will manage their health care by bringing health care issues down to the consumer level where the employee can readily understand what is at stake. This needs to be done to preserve the health care benefits that exist.

Cochairman Collins requested that a copy of this presentation be made available to the members of the committee for review and then they could come back with further questions.

Senator Stegner asked whether a voluntary employee benefit association is different from a VEBA. **Ms. Sandberg** stated that in Idaho a volunteer benefit association is a trust that is available for public employers. Under IRS rules, it is the same as a VEBA.

Keith Bybee, LSO, discussed Idaho's Flexible Spending Account (FSA) for medical reimbursement. (A handout provided by Mr. Bybee is on file at LSO.) Idaho's FSA is a special account authorized by the IRS that helps employees pay certain eligible expenses on a pretax basis. Employees are eligible to enroll on the first day of employment as long as they are eligible for health care benefits. The FSA is a type of a Consumer Directed Health Plan (CDHP) in which consumers make choices about health care spending. There are two types : 1) Health Reimbursement Accounts (HRAs); and 2) Health Savings Accounts (HSAs).

Representative Marriott commented that if the employee has a high deductible of $5,000, the reduction in premium is not to justify the high deductible. **Cochairman Cameron** agreed that may be true in some years but it depended on the company and pricing. There have been years when it was substantially cheaper to go to a higher deductible plan. In some cases, an HSA could be funded and still save money within that group by going to a higher deductible plan that employees are able to manage. In some situations it doesn't make sense because either the existing product is very competitively priced, even though it may have a lower deductible. Under such a situtation, there is not enough savings to warrant doing an HSA.

Representative Henbest distributed two articles relative to CDHPs and how to change consumer behaviors for the Task Force member to review at their leisure. (These articles are on file at LSO.)

Rakesh Mohan, Director, Office of Performance Evaluations, provided the Task Force with an update on the Health Care Costs and Options Study, assisted by **Lynn Blewett**, State Health Access Data Assistance, University of Minnesota and **Lyn Quincy**, Mathematica Policy Research, Inc., who participated telephonically. (Handouts and a copy of the slide presentation provided by **Mr. Mohan** are available at the LSO.)

Mr. Mohan overviewed the history of the study which was done as a result of Senate Bill 1340 (2006). Two consulting firms were engaged: Mathematica Policy Research, Inc. And State

Health Access Data Assistance Center, School of Public Health, University of Minnesota with quality control carried out by Tedd McDonald, Director, Master of Health Sciences Program, Boise State University, and Robert C. Thomas and Associates, of the state of Washington. The study resulted in five reports which are available on the Idaho Office of Performance Evaluations' website http://www.legislature.idaho.gov/ope/ along with the executive summaries for each of these five reports.

This independent study was the first to generate information specific to Idaho. Information was gathered from a comprehensive list of stakeholders to gain an understanding of the issues, challenges and limitations that exist in making health care public policy to gather hard data. The overview included a profile of the uninsured in Idaho, what types of insurance exist in Idaho, and health care expenditures in Idaho. The study showed that Idaho's health care issues are similar to health care issues in other states. The study recommended a "Next Step," the organization of a health care cost summit, authorization of follow-up studies if necessary, and selection of a policy option that would work best for Idaho.

Representative Henbest stated that under the study's options to expand health care coverage, the CAT program received attention in terms of a fairly large pool of money that might be expended in a way that made more sense. There may be opportunities in light of the earlier discussions about the CAT program to work with the consultants to design something better.

Representative Henbest commented that the study's finding that ten percent of Idahoans are uninsured seemed low. **Ms. Quincy** stated that this figure was based on the state's behavioral risk factor survey data for 2005. There is an error bar on the chart indicating that the range of certainty is determined by statistical methods so the estimates should be viewed as rough. Research has been done on some data where actual numbers are available

Representative Henbest identified the relatively high cost from the administrative and overhead standpoint of an individual insurance policy, comparing public administration costs versus private and, within the private, the cost of group coverage versus individual coverage. She inquired, what percent of premium could be attributed to costs. **Ms. Quincy** responded that according to one national study, administrative costs in an individual nongroup premium might represent as much as 40% of the premium whereas, in a group premium, it would be considerably lower. The exact percent would vary inversely with the size of the group. There are not good tools to measure the costs but the amount of effort to underwrite and to sell individual policies makes that cost much higher.

Cochairman Cameron followed up, stating that the comparison between private sector plans and government plans showed a significant administrative cost on the private sector side compared to the public sector side. Blue Cross and Blue Shield have the bulk of the market in this state for both group and individual plans and their figures state that they are running somewhere between nine and eleven percent administrative costs. In contrast, the figure in the presentation was in the 40% range. **Co-chairman Cameron** wondered whether the 40% figure was based on national data. **Ms. Blewett** responded that most of the data for health insurance administrative costs came from the National Association of Insurance Commissioners and is based on information insurance companies are required to report. In addition, Blue Cross of Idaho and Regence Blue Shield provided additional data to supplement the national data. On the private side, in 2006, administrative costs were 23%. **Cochairman Cameron** asked how the 23% was derived, since Blue Cross and Blue Shield are reporting nine to eleven percent in their

public information. **Ms. Blewett** said they would have to research this because it was her recollection that these percentages were based on information supplied by those companies. **Cochairman Cameron** said the report's comparison showed the national private insurance administrative cost at 14.8% and Idaho at 23.2%, is off the mark. **Cochairman Cameron** requested that the researcher review the numbers and get back to the Task Force. **Ms. Blewett** agreed to check the percentages and contact Blue Cross to confirm its data.

Ms. Quincy observed that the footnotes on page 20 in **Ms. Blewett's** *Estimating Private Health Expenditures in Idaho* report, shows that nongroups other expenses were 23% of total premium dollars and that others include administrative expense, as well as profit, and that is just for nongroup. There is also a similar table for group products showing that same data in 2006 as about 14.8% and includes administrative expense and profits. **Cochairman Cameron** agreed that this could be true but that the profit margin is on the group side, not on the individual side, so that there should be a larger percentage administratively on the group side than on the individual side, if profit was the driving reason. **Ms. Quincy** asked if the administrative percentage reported from the two plans was both their group and nongroup combined. **Cochairman Cameron** responded yes.

Senator Werk recognized the difficulty in taking the large amount of information these studies have generated, reviewing it with the relevant stakeholders and making quality recommendations to the Legislature. He expressed concern that unless some kind of official committee is convened to look at the data and try to move forward with it, it will sit on a shelf.

Mike Berry, CEO, American Health Value discussed the evolution and operation of HSAs in Idaho. American Health Value is an Idaho-based company operating in 49 states. It started administrating CDHC plans in 1995. The company was the first independent MSA administrator in the United States. **Mr. Berry** stated that the mission is to provide the most efficient economical and user-friendly product in the market. The whole HSA program relates back to the old three legged stool concept: the insurance carrier who provides the high deductible health plan that is compatible with HSAs, the custodian bank that holds the accounts and the administrator that takes care of the customer service, training, enrollment, provides information and helps maximize the benefits of the HSA.

Mr. Berry stated that the bank American Health Value use has over $1.6 billion in assets. Each HSA account holder gets an individual, interest-bearing checking account with overdraft protection. The account is SPIC insured, and the holder gets a stock of 25 checks and a Visa debit card. There are no transaction fees in the program; a flat annual fee is developed on a client-by-client basis because, statistically, an average family will use the card four times a month which can run up to quite a bit of money. In addition, the bank reimburses the card holder up to $10/month if there are any ATM fees. There are no check writing fees. American Health Value provides monthly statements, annual tax reporting statements, 24/7 web access and access to a live person through an 800 number. A free pharmacy discount card, good at every major chain across the country, is available whether or not a person has insurance coverage. It can be downloaded off their website. There are optional wellness programs and online investment opportunities. (The information provided by Mr. Berry is on file at LSO.)

Mr. Berry discussed the funding of HSAs. Employees can fund anyway the want to. Everything is online. Deposits can be controlled. The balance in the account carries over year after year. There is tax deferred interest. This could be viewed as a medical IRA. If the employer makes a

contribution, it is nontaxable to the employee and deductible to the employer. The employee contribution is tax deductible up to the amount allowable. Any expenditures for medically necessary services comes out tax free. If the employee chooses not to use the money for medical needs, the money can be left in to grow and continue to earn interest. After retirement the money can be used tax free to pay Medicare supplemental premiums, medical expenses, long-term care insurance or many health care items.

Representative Wood asked if there were federal or state tax consequences. **Mr. Berry** responded that there were not. Idaho was one of the first states to develop a MSA. There is a state MSA and a federal MSA. When the two match, there is no federal tax issue. The federal program requires a high deductible health plan that falls within a prescribed range. Under the state MSA, insurance is not required. If no qualifying insurance policy is part of the MSA, contributions would be deductible on the state return but not on the federal.

Representative Wood asked whether the $1,000 catchup contribution after age 55 is one time or annua. **Mr. Berry** stated that catchup contribution will be $1,000 in 2009. The new regulations will probably continue to increase on an annual basis.

Representative Marriott inquired if an individual could buy this plan. **Mr. Berry** explained that half of the American Health Value clients are individual, i.e., self-employed individuals or anyone that has an individual policy. However, an individual cannot have this program and be covered under some other type of health care plan. High deductible health care is readily available. **Representative Marriott** added that you can be on Medicare and still have this plan. **Mr. Berry** answered that once a person is on Medicare at age 65, contributions can no longer be made. The money in the account can be used tax free for any medical expenses.

Cochairman Collins thanked the Task Force members and guests for attending, stating that the day had been very productive in identifying the challenges ahead. The next meeting is scheduled for Monday, November 24.

The meeting adjourned at 3:15 p.m.